STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155328	A. BUILDING _____ B. WING _____	C 06/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPARK REHABILITATION CENTER	**25 S BOEHNE CAMP RD EVANSVILLE, IN 47712**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00148991 and Complaint IN00150417. Complaint IN00148991 - Unsubstantiated, due to lack of evidence. Complaint IN00150417 - Unsubstantiated, due to lack of evidence. Survey dates: June 23 and 24, 2014 Facility number: 000221 Provider number: 155328 AIM number: 100267620 Survey team: Anne Marie Crays RN Census bed type: SNF/NF: 87 Total: 87 Census payor type: Medicare: 14 Medicaid: 57 Other: 16 Total: 87 Sample: 7 Westpark Rehabilitation Center was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00148991 and Complaint IN00150417.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155328	A. BUILDING _____ B. WING _____	C 06/24/2014

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F 000	Continued From page 1 Quality Review 06/25/14 by Lisa McColly	F 000		